STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155730	A. BUILDING 00 B. WING	06/17/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIPLEY CROSSING	1200 WHITLATCH WAY MILAN, IN47031

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for a Recertification and State Licensure Survey. Survey dates: June 13, 14, 15, 16, and 17, 2011 Facility Number: 000420 Provider number: 155730 AIM number: 100266230 Survey team: Diana Sidell RN, TC Penny Marlatt RN Janie Faulkner RN Census bed type: SNF/NF: 94 Residential: 6 Total: 100 Census payor type: Medicare: 13 Medicaid: 61 Other: 26 Total: 100 Sample: 19 Residential sample: 7 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.	F0000	K00 The filing of this plan of correction does not constitute an admission that the alleged deficiency did in fact exist. This plan of correction if filed as evidence of the facilities desire to comply with the regulation will continuing to provide quality of care to all residents.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Quality review completed 6/22/11 Cathy Emswiller RN			
F0333 SS=D	The facility must ensure that residents are free of any significant medication errors. Based on record review and interview, the facility failed to ensure one resident remained free of significant medication errors in that the resident did not receive a physician ordered routine pain medication for 37 days. (Resident #97) Findings include: Resident #97's record was reviewed on 6/16/11 at 1:45 p.m. The record indicated resident #97 was admitted with diagnoses that included, but were not limited to, dementia, rheumatoid arthritis, and osteoporosis. A quarterly minimum data set assessment dated 3/25/11 indicated Resident #97 had modified independence in cognitive skills for daily decision making, and had indicators of pain or possible pain with facial expressions of grimaces, winces, wrinkled forehead, furrowed brow, clenched teeth or jaw. A "PLAN OF CARE" with a revision date of 3/25/11 indicated a problem/need of	F0333	F333 What corrective action will be accomplished: Residents to be free of significant medication errors. 2. How other Residents have the potential to be affected:All residents have the potential to be affected. 3. What measures will be put in place to prevent reoccurrence:Keep yellow copies of new orders on clip board for 5 days to ensure orders are transferred to the emar and nurses are given time to be aware of this new order. 4. How the corrective action will be monitored:Medical Records Designee or ADON to check emar to ensure new orders are added to the emardaily, Monday-Friday. 5. By what date the changes will be completed:6/28/11	06/28/2011

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	"At risk for pain r/t (related to) dx (diagnosis of) arthritis. Goals: Will have no s/s (signs or symptoms of) pain or discomfort noted on daily basis AEB [as evidenced by]: no facial grimacing, no increased restlessness, etc x 90d [for 90 days]. Interventions: 1. meds per order 2. monitor effectiveness of meds...." Physician's recapitulation orders dated 4/1/2011 through 4/30/2011 indicated an order for "Ultram 50 MG (milligrams) take 1 tablet by mouth every 6 hours as needed for pain" A physician's telephone order dated 3/14/11 indicated: "Add Ultram 50 mg po (by mouth) qd @ 8AM." Nurse's notes dated 3/14/11 at 5:40 p.m. indicated: "Received NO (new order) for routine ultram Q8am...updated her on order." Nurse's notes dated 3/15/11 at 8:32 p.m. indicated: "Res continues on routine Ultram. No AVR (adverse reaction) noted. No c/o (complaints of) pain or discomfort. Does not display any s/s of discomfort either." Nurse's notes dated 3/16/11 at 10:00 p.m. indicated: "[No] ASE (adverse side effects) R/T (related to) routine Ultram.			

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	[No] s/s pain. [No] c/o's." Electronic Medication Administration Records (E-MARS) for March 2011 indicated an order for Ultram 50 milligrams 1 tablet by mouth every 6 hours as needed for pain was administered 8 times, and none of the times were within one hour of the 8:00 a.m. routine order. E-MARS for April 2011 indicated an order for Ultram 50 milligrams 1 tablet by mouth every 6 hours as needed for pain was administered 9 times between 4/1 and 4/20 when the physician signed the recapitulation orders for April. The April recapitulation orders did not have the routine daily Ultram order written on the orders and after the physician signed the orders, the order was omitted. A "MEDICATION ERROR REPORT" was provided by the Director of Nurses on 6/17/11 at 4:40 p.m. The report indicated the error was found on 6/16/11 and the description of error included: "N.O. received for routine pain med. dropped from EMAR." The corrective action taken was: "placed back on EMAR." The reason for the error was a transcription error and pharmacy error. The physician was notified.			

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	During an interview on 6/17/11 at 4:40 p.m., the Director of Nurses indicated the Ultram didn't show up on the EMAR, but it had been on there. A "Protocol for new orders to be added to EMAR/TAR", with an effective date of 5/10/10, was provided by the Administrator on 6/16/11 at 9:50 a.m. The Protocol indicated: "Purpose: To provide adequate medication and treatments as ordered by physician. Policy: New orders received are to be faxed to pharmacy and pharmacy will place order in EMAR/TAR. Responsibility: Nurses." 3.1-48(c)(2)			
F0428 SS=E	The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. A. Based on record review, the consultant	F0428	F428	06/28/2011

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	pharmacist failed to review the drug regimen of each resident monthly. This affected 8 of 16 residents in a sample of 19 reviewed for monthly pharmacy reviews. (Residents #27, 57, 64, 76, 97, 37, 48, and 56) B. Based on record review and interview, the consultant pharmacist failed to identify irregularities in that a routine pain medication order was not carried over from the physician's telephone orders to the physician's recapitulation orders. This affected 1 of 16 residents in a sample of 19 reviewed for medication irregularities. (Resident #97) Findings include: A. 1. Resident #27's record was reviewed on 6/16/11 at 9:55 a.m. The record indicated Resident #27 was admitted with diagnoses that included, but were not limited to, degeneration of spine, and decreased bowel motility. A pharmacy computer print-out, provided by the Director of Nurses (DON) on 6/17/11 at 3:15 p.m., indicated the pharmacist had reviewed Resident #27's medication regime on 11/1/10, 4/4/11 and 5/4/11. The documentation lacked pharmacy		What corrective action will be accomplished: Pharmacy consultant reviews will be documented in resident record with date and pharmacist signature each time the record is reviewed by the pharmacist no matter whether the resident has recommendations or not. 2. How other Residents have the potential to be affected:All residents have the potential to be affected. 3. What measures will be put in place to prevent reoccurrence:Pharmacy consultant log has been placed into the resident record under the physician orders tab for the pharmacist to sign and date with each review. 4. How the corrective action will be monitored:DON/ADON to check these logs monthly for documentation of review for 6 months 4. By what date the changes will be completed:6/28/2011	

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	reviews between 11/1/10 and 4/4/11. A. 2. Resident #57's record was reviewed on 6/13/11 at 2:03 p.m. The record indicated Resident #57 was admitted with diagnoses that included, but were not limited to, coronary artery disease, depression, osteoporosis, failure to thrive, high blood pressure, and dementia. A pharmacy computer print-out, provided by the Director of Nurses (DON) on 6/17/11 at 3:15 p.m., indicated the pharmacist had reviewed Resident #57's medication regime on 7/6/10, 9/4/10, 3/1/11, 4/4/11, and 5/2/11. The documentation lacked pharmacy reviews between 7/6/10 and 9/4/10, and from 9/4/10 through 3/1/11. A. 3. Resident #64's record was reviewed on 6/15/11 at 2:35 p.m. The record indicated Resident #64 was admitted with diagnoses that included, but were not limited to, dementia with behaviors, anemia, degenerative joint disease, high blood pressure, and chronic back pain. A pharmacy computer print-out, provided			

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	by the Director of Nurses (DON) on 6/17/11 at 3:15 p.m., indicated the pharmacist had reviewed Resident #64's medication regime on 10/7/10, 4/4/11, 5/2/11, and 6/8/11. The documentation lacked pharmacy reviews between 10/7/10 and 4/4/11. A. 4. Resident #76's record was reviewed on 6/14/11 at 9:45 a.m. The record indicated Resident #76 was admitted with diagnoses that included, but were not limited to, chronic pain, quadriplegia, pancreatitis, and contractors. A pharmacy computer print-out, provided by the Director of Nurses (DON) on 6/17/11 at 3:15 p.m., indicated the pharmacist had reviewed Resident #76's medication regime on 1/6/11, 4/5/11, and 5/6/11. The documentation lacked pharmacy reviews between 1/6/11 and 4/5/11. A. 5. Resident #97's record was reviewed on 6/16/11 at 1:45 p.m. The record indicated Resident #97 was admitted with diagnoses that included, but were not limited to, dementia, rheumatoid arthritis, and osteoporosis.			

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	On 6/17/11 at 3:15 p.m., the DON provided a computer print-out which indicated the pharmacist had reviewed Resident #97's medication information on 10/4/10, 5/1/11 and 6/6/11 with no recommendations. The documentation lacked pharmacy reviews between 10/4/10 and 5/1/11. A. 6. Resident 37's clinical record was reviewed on 6-14-11 at 11:45 a.m. Her diagnoses included, but were not limited to, diabetes mellitus, history of CVA (cerebrovascular accident or stroke), anxiety and elevated blood lipids. Her record indicated she was admitted to the facility on 1-21-11. Review of the pharmacy review included in the clinical record indicated a document which indicated the pharmacist had reviewed her medication information between 1-27-11 and 2-7-11, within the first month of admission to the facility. On 6-17-11 at 3:15 p.m., the DON provided a computer print-out which indicated the pharmacist had reviewed Resident #37's medication information on 4-4-11 with no recommendations listed and again on 5-1-11 which indicated the resident's CBC (complete blood count) and lipid lab results were due in April and were not yet in the clinical record.			

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This documentation indicated a lack of pharmacy review for the month of March 2011.

A. 7. Resident #48's clinical record was reviewed on 6-15-11 at 10:05 a.m. Her diagnoses included, but were not limited to, Alzheimer's disease, dementia, depression, insomnia, anxiety, hypertension (high blood pressure) and a history of TIA's (transient ischemic attacks or mini-strokes). Her record indicated she was admitted to the facility on 8-8-07.

Review of the clinical record did not indicate documentation of a pharmacy review in the time period 7-1-10 through 6-1-11.

On 6-17-11 at 3:15 p.m., the DON provided a computer print-out which indicated the pharmacist had reviewed Resident #48's medication information on 7-5-10, 9-2-10, 12-1-10, 1-3-11, 1-31-11, 4-4-11, and 5-1-11. Recommendations were documented by the pharmacist on 7-5-10 with no recommendations cited on the remaining dates.

The documentation indicated a lack of pharmacy reviews for August 2010,

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	October 2010, November 2010, or March 2011. A. 8. Resident #56's clinical record was reviewed on 6-16-11 at 10:12 a.m. Her diagnoses included, but were not limited to, mental retardation, seizure disorder, depression, anxiety, osteoporosis, hypertension (high blood pressure), hypothyroidism, itching/Pruritis, vitamin B-12 deficiency and GERD (hiatal hernia/heartburn/stomach problems). Her record indicated she was admitted to the facility on 12-29-09. On 6-17-11 at 3:15 p.m., the DON provided a computer print-out which indicated the pharmacist had reviewed Resident #56's medication information on 7-6-10, 8-4-10, 9-5-10, 4-4-11, and 5-2-11. Recommendations were documented by the pharmacist on 5-2-11 with no recommendations cited on the remaining dates. The documentation indicated a lack of pharmacy reviews for October 2010, November 2010, December 2010, January 2011, February 2011 or March 2011. In an interview with the DON on 6-17-11 at 4:20 p.m., she indicated the contracted pharmacist reviewed each resident's			

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	clinical record each month. The DON indicated he generally only provided documentation of problems [issues that may need a physician's attention or the facility's attention]. She indicated the facility would occasionally receive computer printouts of residents with the comments, "okay or no problem." The DON indicated the pharmacist indicated he had some problems with his computer which did not allow him to print out individual records for each resident or the computer did not identify specific visit dates. She indicate the facility did not have any other information to identify when or whom the pharmacist had reviewed. She indicated the pharmacist had sent a list of individual resident's he had reviewed on this date. B. Resident #97's record was reviewed on 6/16/11 at 1:45 p.m. The record indicated resident #97 was admitted with diagnoses that included, but were not limited to, dementia, rheumatoid arthritis, and osteoporosis. Physician's recapitulation orders dated 4/1/2011 through 4/30/2011 indicated an order for "Ultram 50 MG (milligrams) take 1 tablet by mouth every 6 hours as needed for pain"			

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	A physician's telephone order dated 3/14/11 indicated: "Add Ultram 50 mg po (by mouth) qd @ 8AM." Nurse's notes dated 3/14/11 at 5:40 p.m. indicated: "Received NO (new order) for routine ultram Q8am...updated her on order." On 6/17/11 at 3:15 p.m., the DON provided a computer print-out which indicated the pharmacist had reviewed Resident #97's medication information on 5/1/11 and 6/6/11 with no recommendations. On 6/17/11 at 10:48 a.m., the Administrator provided a document titled: "Ripley Crossing Consultant Pharmacist Contract" which is in effect until August 31, 2011. The Contract included, but was not limited to..."2. CONSULTANT RESPONSIBILITIES...a. Review the drug regimen of each resident in Home at least once each month and report in writing any irregularity to Home's Administrator, Medical Director, Director of Nursing Services, and, where appropriate, the individual resident's physician...." 3.1-25(h)			

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F0514 SS=D	The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. Based on interview and record review, the facility failed to ensure Resident #72's written advanced directive and the physician signed recapitulation orders were in agreement in regard to resuscitation status. This deficient practice affected 1 of 19 resident's reviewed for advanced directives in a sample of 19. Findings include: Resident #72's clinical record was reviewed on 6-15-11 at 3:17 p.m. His diagnoses included, but were not limited to, right hip fracture and repair, anemia, esophagitis, hypertension (high blood pressure), diabetes mellitus, CAD	F0514	F514 What corrective action will be accomplished: Advanced Directive to match code status on physician orders. 2.How other Residents have the potential to be affected:All residents have the potential to be affected. 3. What measures will be put in place to prevent reoccurrence:Advanced Directive to be added to admission packet for the nurse to complete rather than social services completing after the nurses admission. 4. How the corrective action will be monitored:DON/ADON to check new admissions to verify code status matches on all new admissions x 90 days, if discrepancies are found, repeat	06/28/2011

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	(coronary artery disease), pacemaker, and a history of prostate cancer. The clinical record indicated this 90 year-old man was admitted to the facility on 5-26-11 following a fall at home in which he fractured his right hip and was hospitalized for surgical repair of the fracture. Review of the recapitulation orders for 6-1-11 through 6-30-11 and signed by the physician on 6-14-11, indicated the resident was listed as a "full code," which typically indicates all means of resuscitation would occur in the event the resident stopped breathing or his heart stopped beating. Review of the resident's advanced directive information indicated the resident's spouse signed the document on 5-26-11 to indicate a desire for "No CPR (cardiopulmonary resuscitation)," in the event the resident stopped breathing or his heart stopped beating. This document was signed by the social services representative on 5-26-11 and by the physician on 5-27-11. In interview with the Director of Nursing (DON) on 6-17-11 at 3:30 p.m., she indicated the nurse who admitted the resident indicated to the DON that the resident initially indicated he wished to be		the90 day monitoring. If no discrepancies, random monitoring will be completed by DON x 6 months & followed by QA team.5. By what date the changes will be completed:6/28/2011	

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	a full code. The DON indicated that later when the social services staff discussed the code status with the resident and his wife, they changed their minds, and signed for the no code (status.) She indicated, however, the order for this did not get written. 3.1-50(a)(2)			
F0516 SS=E	A facility may not release information that is resident-identifiable to the public. The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. The facility must safeguard clinical record information against loss, destruction, or unauthorized use. Based on observation, interview, and record review, the facility failed to safeguard clinical records in that an unlocked storage room that contained 56 boxes of medical records was observed unlocked for 1of 5 survey days. Findings include:	F0516	F516 What corrective action will be accomplished: Medical records to be safeguarded. 2. How other Residents have the potential to be affected:All residents have the potential to be affected. 3. What measures will be put in place to prevent reoccurrence:Lock has been replaced with a lock that	06/28/2011

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	155730	A. BUILDING 00 B. WING	06/17/2011

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	The environmental tour was begun on 6/14/11 at 2:35 p.m., with the Housekeeping Supervisor. At 3:12 p.m., an unlocked storage room in the shower room outside of Wing 4 was observed to be unlocked. The storage room had three shelves with boxes of resident's medical records marked "closed records" on the boxes. The top shelf had 24 boxes, the middle shelf had 16 boxes, and the bottom shelf had 16 boxes. On 6/14/11 at 3:15 p.m., the Housekeeping Supervisor indicated the door was supposed to be locked. On 6/14/11 at 3:16 p.m., the Medical Records Supervisor indicated the records were closed records. On 6/14/11 at 1:50 p.m., the Director of Nurse's provided a policy for "Confidentiality of Records". The Policy indicated: "Purpose: To maintain personal records while protecting the privacy of the information within the record. Policy: Insure the following...4. Records will be maintained confidentiality...." 3.1-50(d)		must be in the locked position in order to remove the key, therefore ensuring the door be kept locked. 4. How the corrective action will be monitored:Administrator will check door daily, Monday-Friday x's 1 week then weekly for 3 weeks. If door is found unlocked, continue the monitoringx 6 months. The door will be monitored at random during the "rounds"made by the Adm & DON x 6 months. QA team will monitor. 5. By what date the changes will be completed:6/28/2011	

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R0000	THESE STATE RESIDENTIAL FINDINGS ARE CITED IN ACCORDANCE WITH 410 IAC 16.2-5.	R0000	K00 The filing of this plan of correction does not constitute an admission that the alleged deficiency did in fact exist. This plan of correction if filed as evidence of the facilities desire to comply with the regulation will continuing to provide quality of care to all residents.	
R0246	(6) PRN medications may be administered by a qualified medication aide (QMA) only upon authorization by a licensed nurse or physician. The QMA must receive appropriate authorization for each administration of a PRN medication. All contacts with a nurse or physician not on the premises for authorization to administer PRNs shall be documented in the nursing notes indicating the time and date of the contact. Based on record review and interview, the facility failed to ensure QMAs (qualified medication aides) obtained authorization from a licensed nurse to administer PRN(as needed) medication prior to	R0246	R246 What corrective action will be accomplished: Nurses will co-sign PRN medications that they approve to be given by the QMA. 2.How other Residents have the	06/28/2011

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	administering the medication. This affected 2 of 3 residents in a sample of 7 residents reviewed for QMA authorization from licensed nurse prior to administering PRN medications. (Resident #100, #105) Findings include: 1. On 6/14/2011 at 9:00 a.m., review of clinical record for Resident #100, pages 2 & 3 of the April "MAR"(Medication Administration Record) indicated the resident received PRN Tylenol 2 times on 4/10/11 for headache from Employee #1/QMA, on 4/15/11 for leg pain from Employee #2/QMA, on 4/16/11 from Employee #1/QMA, on 4/18/11 for headache from Employee #2/QMA, on 4/25/11 from Employee #2/QMA, and on 4/28/11 from Employee #2/QMA. All of preceding dates had E or EFF(effective) with QMA initials. There was no documentation indicating a licensed nurse had given authorization to the QMA to give the Tylenol to this resident on the MAR or in nurse's note. Review of pages 2 & 3 of the May "MAR" indicated Resident #100 received PRN Tylenol on 5/1/11 from Employee #3/QMA, on 5/6/11 from Employee #3/QMA, on 5/7/11 from Employee #1/QMA, on 5/8/11 from Employee #4/QMA, on 5/9/11 from Employee		potential to be affected: All residents have the potential to be affected. 3.What measures will be put in place to prevent reoccurrence: PRN log has been put in place for the QMA to document the PRN given and the nurse who authorized the PRN to co-sign. 4.How the corrective action will be monitored: DON/ADON to check log daily Mon.-Fri. for 4 weeks then weeklyx 2 months. 5.By what date the changes will be completed: 6/28/2011	

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	#4/QMA, on 5/14/11 from Employee #4/QMA, on 5/19/11 from Employee #3/QMA, on 5/25/11 from Employee #3/QMA, and on 5/31/11 from Employee #3/QMA. All of preceding dates had eff, effect, or a check mark in result box with QMA initials with exception of 5/19/11 initials not on list of QMAs and no signature and title on page 2 of the MAR for May 2011. There was no documentation indicating a licensed nurse had given authorization to the QMA to give the Tylenol to this resident. Review of a document titled "QMA -Approved Tasks", provided by the Director of Nursing on 6/15/11 as their current Policy and Procedure indicated, "Administer previously ordered PRN medication only if authorization is obtained from the facility's licensed nurse on duty. If authorization obtained the QMA must: (A) Document in the resident record symptoms indicating the need for the medication and time the symptoms occurred. (B) Document in the resident record that the facility's licensed nurse was contacted, symptoms were described, and permission was granted to administer the medication, including the time of contact. (C) Obtain permission to administer the medication each time the symptoms occur			

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	in the resident." 2. On 6/15/2011 at 11:15 a.m., Resident # 105's clinical record was reviewed, indicating the resident received PRN Tylenol on 4/1/11 for generalized discomfort from Employee #3/QMA, with result effective initialed by the QMA. There was no documentation indicating a licensed nurse had given authorization to the QMA to give the Tylenol to this resident.			

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R0349	(a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. Based on record review the facility failed to ensure the Pre-Admission Evaluations were signed by the evaluators. This affected 2 of 7 residents in a sample of 7 reviewed for accuracy of the Pre-Admission Evaluations. (Resident #100 and Resident # 105) Findings include: 1. Review of Resident #100's Pre-Admission Evaluation dated 3/30/11 had the resident's signature, the "Nurse signature" line was blank. 2. Review of Resident #105's Pre-Admission Evaluation dated 3/25/11 had no resident/POA (power of attorney) signature and no nurse signature. Based on record review and interview the facility failed to ensure Nursing Assessments were signed and dated by the nurse. This affected 4 of 7 residents in a sample of 7 reviewed for accuracy of	R0349	R349 What corrective action will be accomplished: Nurses/facility representatives will sign assessments. New nursing assessmentshave been completed on 6 of 6residents. 2. How other Residents have the potential to be affected: All residents have the potential to be affected. 3. What measures will be put in place to prevent reoccurrence:A signature line has been added to cue the nurses/facility representatives to sign the Assessment forms. 4. How the corrective action will be monitored: DON/ADON to check new admissions and routine assessments for 6 months. 5. By what date the changes will be completed: 6/28/2011	06/28/2011

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	Nursing Assessments. (Resident #31, Resident #38, Resident #104, and Resident #105) Findings include: 1. Review of Resident #38's clinical record on 6/14/2011 at 10:00 a.m., indicated a "Nursing Assessment" with admission date 3/21/11 filled out with no nurse's signature. 2. Review of Resident #31's clinical record on 6/14/2011 at 10:40 a.m., indicated a "Nursing Assessment" with admission date 3/17/11 filled out with no nurse's signature. 3. Review of Resident #104's clinical record on 6/15/2011 at 10:15 a.m., indicated a "Nursing Assessment" with admission date 3/19/11 filled out with no nurse's signature. 4. Review of Resident #105's clinical record on 6/15/2011 at 11:15 a.m., indicated a "Nursing Assessment" with admission date 3/25/11 filled out with no nurse's signature. During an interview with the Director of Nursing on 6/14/2011 at 10:55 a.m., she indicated that all assessments for residents should be signed and dated by the nurse			

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	doing the assessment. Review of the Third Edition of Fundamentals of Nursing, Potter and Perry, indicated: "...Table 22-4 Legal Guidelines for Recording...Begin each entry with time and end with your signature and title. [Rationale] This ensures that correct sequence of events is recorded. Signature documents who is accountable for care delivered...."			